EXHIBIT 10

0032280343

VISITING NURSE
HOSPICE ATLANTA

PATIENT AGREEMENT

PATIENT NAME: Velma Hinton **VN #:** ______

I Velma Hinton have received an explanation of hospice care and services from ______ on 3-8-09, effective ______

I elect to have Hospice Atlanta provide comprehensive care for my life-limiting illness and complications arising from that illness. I acknowledge that I have been given a full understanding of the palliative rather than curative nature of hospice care.

I understand that my illness is life-limiting and that Hospice provides supportive rather than curative treatment. The goals of hospice care will be to help me remain comfortable, to relieve pain and suffering and to provide emotional support to me and my family.

☑ I **do not** want my life to be prolonged and I want to allow natural death. I want to receive only medicine and treatments to control pain and keep me comfortable when my death is expected.

☐ I **do** want my life to be prolonged to the extent possible, using artificial means if necessary.

RIGHTS/ADVANCE DIRECTIVES: I certify that I have received the Patient Admission Booklet which includes my Patient's Rights and Responsibilities, written materials on my right to refuse or accept medical and surgical treatment, and my right to formulate an advance directive. I certify that I have read each of the documents or that they have been explained to me and that I understand the information.

☐ I do not have an advance directive.

☐ I have executed an advance directive and will provide a copy to Hospice Atlanta, I understand that Hospice Atlanta will not be able to follow the terms of my advance directive until I provide them a copy.

I realize that whenever possible, hospice care will be provided in my place of residence and will consist of regular visits by members of the hospice interdisciplinary team and trained volunteers. The hospice interdisciplinary team will direct my care and Dr. Linda Britton / Terry Schwartz whom I am designating as my attending physician, will work with the hospice team. Dr. John Biessler.

IF AN EMERGENCY ARISES OR I NEED IMMEDIATE ASSISTANCE, I AGREE TO CONTACT THE HOSPICE STAFF. I understand a staff member is on-call 24 hours a day at (404) 869-3000. I acknowledge that should I seek medical care without authorized from Hospice Atlanta, I may be financially responsible.

I am aware that I may discontinue hospice services at any time by notifying Hospice Atlanta and signing the Revocation Form.

☐ ***ASSIGNMENT OF BENEFITS/FINANCIAL AUTHORIZATION:*** I agree to allow Hospice Atlanta to bill the third party listed below on an assignment of benefits basis for health services provided to me. I further authorize payment directly to Hospice Atlanta of any benefits for health services. I also agree that I am financially responsible and will pay all charges not paid by any third party payer including, but not limited to, any deductibles, coinsurance, or any nonpayment in whole or in part by the third party payer. *(Check expected payer(s) for services.)*.

Name of Beneficiary: Velma Hinton

☐ **Medicare #:** see face sheet ☐ **Medicaid #:** ______

☐ **Insurance Company:** ______ Phone #: ______

Policy Holder Name: ______

Policy/Contract #: ______ Group #: ______

If you have insurance, our financial counselors have verified coverage.

☑ a. You are covered at 100% and have no financial obligation except for items not authorized by Hospice Atlanta.

☐ b. Your policy covers ______% which makes your financial responsibility $______ per day as well as for items on the covered/non covered form.

☐ c. Your policy has no maximum limit;

☐ d. Your policy has a maximum limit of $______.

☐ ***CHARITABLE ALLOWANCE:*** I am unable to pay for any services, or my responsible portion of those services. I am requesting a financial assessment to determine my eligibility for a charitable allowance.

☐ ***SELF PAY:*** I agree that I am financially responsible and will pay all charges for services received.

[signature] 3/8/09 Sherri Moon

Patient's or Legal Representative's Signature — Date — Print Full Name of Patient or Legal Representative

Daughter POA

Relationship of Legal Representative — Reason Patient Unable to Sign

[signature] 3-8-09 Debra Elley RN

Hospice Atlanta Representative — Date — Print Full Name

2009-04-16 06:00 DR SMOON 7702220137 >> GLOBE LIFE p 7/9